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THE PATHOLOGY AND TREATMENT OF ANTE PARTUM HEMORRHAGE

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Excepting lacerations of the cervix, practically all varieties of ante partum hemorrhage are due to a premature partial, or complete detachment of the placenta either from a normal site of implantation in the cavity of the uterus, or from an abnormal site of implantation in the region of the internal os. This paper will not attempt a detailed discussion of the subject, but will deal briefly with the differential diagnosis of premature separation of the normally implanted placenta and placenta previa, and with certain other points which, because of their importance, seem to justify reiteration, and finally will outline the methods of treatment which have been employed in the Women's Clinic at Yale.

The type of bleeding in question may without warning become formidable in character, and for this reason it is generally accepted that women presenting this symptom be immediately admitted to a hospital equipped to care for such obstetrical complications. Of equal importance in the treatment of such patients are the determination of the site of bleeding, the control of hemorrhage, transfusions, and the method of delivery chosen in the individual case.

Three means for differential diagnosis are available to the clinician:—the history, and the findings upon abdominal, and upon vaginal examination. The history is frequently equivocal since bleeding —the outstanding symptom—is common to both placenta previa and premature separation. It is generally stated that the presence of placenta previa is announced by recurrent attacks of hemorrhage which become gradually more severe, but in a large proportion of cases the first loss of blood is profuse. The bleeding may arouse the patient from her sleep; in other instances it may be associated with straining incident to coughing or sneezing. Generally the first hemorrhage occurs during the last trimester of pregnancy, although on the other hand there may be no loss of blood until the onset of labor. The bleeding is not associated with pain and this statement is also true in those instances of premature separation of the placenta associated with mild external bleeding. On the other hand abdominal pain is an outstanding symptom in women suffering from premature separation of the placenta with an extensive concealed hemorrhage. This pain frequently is intense and coliclike, and sometimes is associated with sudden, violent fetal movements which rapidly subside. Such a statement regarding the character of the fetal movements indicates almost certainly that the placental separation has caused the death of the fetus. If in either complication the loss of blood is excessive, the patient presents signs of anaemia and may be in a condition of profound shock.

Abdominal examination in patients with placenta previa shows nothing definitive, and the uterus will be found to be of the consistency usual in pregnancy. Similarly in the milder degrees of premature separation with external bleeding there is generally no outstanding change in the consistency of the uterus, although occasionally there is pain upon uterine palpation.

The abdominal picture in premature separation with concealed hemorrhage is wholly different. The uterus is of a characteristic ligneous consistency and often is abnormally distended as the result of hemorrhagic infiltration of the myometrium and of free bleeding into the uterine cavity. The fetal small parts are felt with difficulty, if at all, and the fetal heart beat is inaudible. In the absence of external bleeding, the characteristic pain mentioned above together with the ligneous consistency of the uterus are almost pathognomonic of premature separation of the placenta, and this diagnosis is assured if, in

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addition, the patient presents evidences of anaemia and shock, which are often out of proportion to the quantity of blood loss.

The grave dangers associated with a vaginal examination in the possible presence of placenta previa cannot be too greatly stressed. Even though the loss of blood has been slight previous to hospitalization, the digital manipulation necessary on vaginal examination may be sufficient to cause further placental detachment and a sudden profuse hemorrhage. Therefore, no patient in whom placenta previa is suspected should be examined vaginally until all is in readiness for immediately controlling homorrhage, inducing labor or emptying the uterus.

The vaginal examination is of importance in differentiating between premature separation with external bleeding and placenta previa. The diagnosis of the former abnormality is made positive by the presence of a cervix of normal consistency and the absence of placental tissue situated in the region of the internal os. In placenta previa, on the other hand, the cervix is usually softer and more succulent than is usual at this period of pregnancy. The cervical canal is generally sufficiently patulous to admit a finger and, excepting those instances in which the placenta is marginally implanted, a layer of spongy, boggy tissue is felt between the fetal head and the tip of the examining finger. When only the lower margin of the organ is inserted in the region of the internal os, it is generally impossible to palpate placental tissue until the cervix becomes more fully dilated.

Having determined whether the pregnancy is complicated by premature separation of the normally implanted placenta or by placenta previa, the next problem concerns the type of treatment which is to be employed. In this connection it is well to recall that the bleeding site in premature separation of the placenta is located in the cavity of the uterus. The placental detachment is inaugurated by hemorrhage into the basal decidua, and in the early stages consists of a decidual hematoma which brings about a separation and compression of portions of the placenta. In concealed hemorrhage blood accumulates in and distends the uterine cavity and myometrial hemorrhage with disassociation of muscle fibres may occur. Under such circumstances the normal hemostatic control of bleeding is in abeyance and satisfactory muscular contractions cannot occur until the uterus is emptied.

In placenta previa we are faced with bleeding from the vascular placental bed in the lower uterine segment. Moreover, the friability of the latter structure is notably increased by the invasion of chorinic villi. Carefully applied pressure will control the bleeding; injudicious attempts to bring about cervical dilatation will open venous sinuses and provoke increased bleeding.

There is no uniform viewpoint respecting the treatment of premature separation of the normally implanted placenta. It may be said, however, that no one type of treatment is applicable to all cases and that each patient should be regarded as an individual problem. When the hemorrhage is external infiltration of the myometrium is unlikely and the prognosis depends upon the severity of the bleeding. In milder degrees of separation, this is not enough to interfere with the fetal circulation and the complication may be without serious significance. We are accustomed to treat such patients conservatively so long as the bleeding is not acute and to permit labor to progress without interference beyond artificial rupture of the membranes and, perhaps, the administration of pitocin intranasally. On the other hand, we regard acute external or concealed internal hemorrhage as a clear indication for emptying the uterus without delay and, unless the patient is well advanced in the second stage of labor, we effect delivery by cesarean section. The abdominal approach seems clearly indicated when the hemorrhage is concealed, for it is impossible from abdominal palpation to determine the extent of hemorrhagic infiltration or to predict the ability of the uterus to contract satisfactorily following delivery. Whether the uterus is left in situ or is excised depends upon the appearance and the reaction of the uterine musculature. In about one out of every four cases the myometrial injury will have been so extensive as to prevent satisfactory contractions and the purplish uterus lies limp following the delivery of the fetus and placenta. We feel it unsafe to leave such an organ in situ and remove it by supravaginal hysterectomy. In other instances in which the uterus contracts satisfactorily we follow a conservative course and leave the organ in situ, being prepared to pack its cavity if postpartum bleeding ensues.

The treatment of placenta previa depends upon the general condition of the woman and her fetus upon entrance to the hospital, the type of placenta previa with which one has to deal, and the degree of

cervical dilation. If there has been a severe loss of blood and if upon admission the patient is in shock, morphia should be administered and a transfusion given before any attempts to effect delivery are begun. In those women in whom the placental insertion is marginal and the bleeding is slight, rupture of the membranes is frequently sufficient to inaugurate uterine contractions and bleeding will then be controlled by pressure of the advancing fetal head. In those rarer instances in which upon admission the cervix is fully dilated, labor may be terminated by the application of forceps or by version and extraction as is indicated in the individual case.

It is our experience that the majority of ward patients with placenta previa enter the hospital more or less shocked from the loss of blood, and with the cervix sufficiently dilated to admit two or more fingers with ease. Following the administration of morphia and a transfusion, we prefer in such patients to control the bleeding and to aid in the obliteration of the cervix by rupturing the membranes and introducing a Voorhees' bag to which, in some instances, a weight of two or three pounds is attached. The general condition of these patients and the progress of labor should be carefully supervised. Following the expulsion of the bag, the patient may be allowed to deliver spontaneously or, when the cervix is fully dilated, labor may be terminated by the application of forceps or by version and extraction, as is indicated in the individual case.

Hemorrhage can be similarly controlled by performing a version and bringing down the breech, which forms an effective tampon and so controls bleeding from the affected area. Munro Kerr designates this procedure as the "sheet anchor for practitioners in all countries and climes who are far removed from an obstetric hospital." Moreover, the man in general practice to whom a hospital may be inaccessible is unlikely to be equipped with rubber balloons, which are expensive and disintegrate rapidly, or with the instruments necessary for their introduction.

Some authorities advise external version rather than the intrauterine method of turning the fetus, since the former procedure causes less disturbance at the placental site and decreases the risk of infection. Whichever method is used, the placenta overlying the internal os should be punctured, a foot grasped, and the breech brought down where it acts as an effective tampon. In this connection it should be emphasized that no attempts should be made to complete the extraction until the cervix is fully dilated because of the danger of lacerations, which may extend well beyond the cervix itself. A similar warning may be given respecting manual dilation, or any other rapid method of effacing the cervix, since, as was mentioned earlier, the structure is rendered exceedingly friable from the invasion of the choronic elements of the placenta.

So far I have omitted abdominal cesarean section as a means of treating placenta previa, and I turn to this question concerning which there exists a notable difference of opinion. Since our experience is primarily with ward patients, most of whom are already in labor, we see very few whose condition, or that of the fetus,would justify an abdominal procedure. On the other hand, we have successfully employed cesarean section in certain cases with partial or complete placenta previa seen early in labor or with the cervix slightly more than two fingers dilated. Our choice of this procedure was decided by the satisfactory condition of the mother and fetus before operation. In some patients delivery has been effected by the classical operation—in others by a low cervical section. The latter operation, as has been noted by De Lee and others, offers certain advantages over the classical operation in which the body of the uterus is incised. Since the bleeding in placenta previa comes from the site of implantation in the lower uterine segment, and since there is no physiological hemostatic action in this portion of the uterus, it seems logical to incise at a point where the source of bleeding can be directly attacked. This is possible if a low cervical operation is done, and bleeding sinuses at the site of implantation can be controlled by suturing if necessary. It should be noted, however, that the low cervical section presupposes a considerable degree of skill in pelvic surgery and had best not be undertaken by the occasional operator in this field.

To recapitulate:—Patients suffering from ante partum hemorrhage ought immediately to be hospitalized since the bleeding, although slight in the beginning, may without warning become formidable. Transfusions should be freely employed when indicated. The site of the bleeding should be accurately determined and the method of treatment chosen which will most effectively control the loss of blood and permit delivery with the least degree of shock.

PEAKS AND PIONEERS IN THE HISTORY OF THE THYROID

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Goiter or hypertrophy of the thyroid gland has been recognized for centuries, but due to the more recent discoveries in bio-chemistry, physiology and in treatment of goiter, we are prone to think of hyperthyroidism, myxodema and cretinism as recent discoveries in the field of medicine. Not only is the history of goiter interesting, but to fully appreciate what is really new and what advances have been made, a review of the work of our predecessors becomes essential. Moreover, a review of the history of goiter is a review of the history of the human race.

The Arthorva Veda, an ancient Hindo collection of incantations dating from 2000 B. C., contains extensive forms of exorcism for goiter. Caesar mentions the big neck as a characteristic of the Gauls. Even the expression, cretin, originated with the Romans and shows their familiarity with the disease.

Paracelsus, in the fifteenth century, was the first to emphasize the relationship between goiter and cretinism. The earliest real information on cretinism dates from this time. In 1798, about three centuries later, and again in 1800, Fodere published essays on goiter and cretinism.

The extent to which goiter prevails throughout the world is seldom appreciated. Few countries are free from endemic districts. There are localities where the disease is very common, and these are known as the goiter districts. Probably the best known of these districts is in Southern Europe comprising, Southern Germany, Switzerland, Eastern France and Northern Italy.

The frequency of goiter in North America has been known for a century. In 1800, Barton published a monograph on the occurrence of goiter among the American Indians living along Lake Ontario and Lake Erie. Munson mentions the same condition among Indians living in the Rocky Mountain States. Osler has emphasized the frequency of goiter in Ontario. Marine, more recently, finds the disease widely disseminated along the Great Lakes, where it occurs not only in human beings but also in animals.

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France, in 1864, appointed a commission to study goiter. This commission reported ten years later, in 1874, that they found one half million inhabitants of France suffering from goiter and 120,000 cretins and cretanoid idiots. Switzerland and Italy later appointed similar commissions. As to the cause of goiter, the French Commission seemed to establish as a scientific fact the popular idea that goiter is a water borne disease. Most of the scientific opinion in this country has been that it is a deficiency disease. Following, in the fifteenth century, the discovery by Paracelsus of the relationship existing between goiter and cretinism, Parry in 1825, three centuries later, pointed out the connection between goiter and enlargement of the heart, associated with palpitation and exophthalmos. Basedow's description of the same symdrome appeared in 1840. While these observers made important contributions, none interpreted their findings in terms of the function of the thyroid gland. Sir William Gull, in 1874, published the first important observation on the functions of the thyroid. At this time the clinical complex of Myxedema (Gull's Disease) was described in detail and interpreted as a lack of function of the thyroid.

In 1913, Plummer suggested separation of the hyperthyroid states into two clinical entities. Exophthalmic goiter he associated with diffuse hyperplasia of the thyroid gland, while a condition in which there was no diffuse hyperthropy or hyperplasia of the thyroid gland and a different physiologic status, he considered to be in another group in which the hyperfunction originates in a tumor of the gland. The latter group he has called toxic adenoma or adenomatous goiter with hyperfunction. The question of classification has always been a disputed one. Means recognizes exophthalmic goiter or diffuse hyperplasia of the gland. He also admits cases fulfilling the description of Plummer's type and the points in which they differ from a classic Graves' disease, but because of so many intermediate types possessing features of each type, prefers to group them all under one group, "Toxic Goiter." Plummer also improved Parry's work, recognized patients suffering from cardiac injury as suffering from hyperthyroidism and found that

relief from hyperthyroidism was followed by improvement in the cardiac status.

The Chinese, 4000 years ago, and the early Greeks, treated goiter by internal administration of the ash of burned sea sponges, not knowing that it contained iodine. Iodine made from seawood was discovered in 1812. Iodine was first knowingly used in the treatment of goiter by Coindet in 1820. Since then it has been widely used by various methods; inhalations, internal administration and cutaneous application. In 1907, Marine established the fact that iodine is necessary for normal function of thyroid and also that in active hyperplasia of the thyroid there is a reduction of the iodine content. Kendell, in 1914, isolated the active principle of the thyroid, thyroxin in crystalline form. Investigations with thyroxin produced evidence warranting Plummer's conclusion that thyroxin is a catalytic agent hastening the rate of formation of a quantum of potential energy available for transformation on excitation of the cells. Trousseau, in 1863, first described the effect of iodine on toxic goiter. This valuable information, gained through an error by giving iodine instead of digitalis, did not lead to general use. Kocher, in 1904, advocated the use of iodine in hyperthyroidism but soon abandoned its use, believing it to be contraindicated. Marine and Lenhart, in 1911, advocated its use in toxic cases but again iodine failed to be accepted by the profession generally. In 1923, Plummer reintroduced the use of iodine in the preparation of exophthalmic goiter patients for operation and through his efforts the use of iodine treatment in hyperthyroidism was popularized.

The determination of the basal metabolic rate has added much in the diagnosis of hyperthyroidism. By means of the basal metabolism many patients have been found to be in a state of hyperthyroidism which otherwise would have gone unrecognized. According to Pemberton, the three greatest advances in the diagnosis of exophthalmic goiter since the time of Parry, Graves and Basedow are the determination of the basal metabolic rate, knowledge gained from Plummer's classification, and the effect of iodine.

Since the earliest recognition that the symptoms of exophthalmic goiter were associated with activity of the thyroid gland, the most successful method of combating the disease was by operation to reduce the function of the gland. Before 1850, operation upon the thyroid had been performed on seventy cases with no report of mortality. Billroth, in 1869, had operated on twenty cases with forty percent mortality. Kocher performed his first thyroid operation in 1872, and at the time of his death, in 1917, had performed approximately 5000 operations for goiter. To these European surgeons and our own American pioneers in goiter surgery, like Halstead, Mayo, McGuire, Crile, Lahey, Pemberton and others, full credit must be given. However, for many years the advances made were slow and did not equal the progress made in other branches of general surgery.

Removal of the simple nodular goiter for the most part met with success dependent upon good technic and asepsis. However, conditions were different in toxic goiters. Experience early indicated that there were other problems besides asepsis and technical ability. The operative mortality was high, the cause of death in such cases was not understood and shrouded in mystery. Few surgeons were willing to undertake the operation. The hazards of operation on an adenomatous goiter with hyperthyroidism were dependent upon the presence of visceral degeneration. To offset this danger, early diagnosis, and early operation was practiced, whereas, the institution of early operation in exophthalmic goiter would only partically solve the problem.

Formerly the most baffling and discouraging problem in the treatment of exophthalmic goiter was the frequent occurrence of post-operative thyroid crises. Within a few hours after the goiter had been successfully removed, an acute explosive reaction would follow, with extreme tachycardia, high fever, nausea and vomiting, restlessness, prostration and delirium, followed in twelve to forty-eight hours by death. Such disastrous complications lead to the substitution of minor surgical procedures preliminary to operation such as ligation of the superior and inferior thyroid arteries, X-ray, injection of drugs and hot water into the gland. Such procedures were helpful and no doubt saved many lives, but, in spite of these improvements, there still remained many disadvantages and failures in this method of treatment.

First, there was no satisfactory treatment for the acutely sick patient bordering on a crisis. Experience had taught that operation was definitely contraindicated in such cases. Treatment remained symptomatic.

Second, the method did not completely eliminate post-operative reactions. Crises and death occasionally followed a minor operation, such as ligation or injection.

Third, since there was no absolute criteria of the patients condition, the surgeon, to avoid hidden pit falls and unseen hazards, wisely judged a large per cent of all cases as poor risks and operated in multiple stages in a large number of cases which might easily have undergone a primary thyroidectomy. This resulted in a tremendous economic waste. It was amid these conditions, in 1913, that Plummer first established the value of the administration of iodine (compound solution of iodine) to patients with exophthalmic goiter who were under preparation for operation. This ushered in a new era in the treatment of this disease. Administration of iodine controls the spontaneous crisis of the disease and thereby has greatly reduced the medical mortality. Its effect is temporary relief not curative, for experience indicates that prolonged administration of iodine offers little hope of affecting permanent cure. By far the greatest value derived from this form of treatment has come from its employment as a measure of preparation for operation.

C. H. and C. W. Mayo, in reviewing 37,000 cases of goiter at Mayo Clinic, found that the hospital mortality in exophthalmic goiter had been reduced one fourth of what it had been before the use of iodine. Impressive as this may be, it does not tell the whole story, namely, the increase in operability which results from the use of iodine; likewise, the very marked decrease in medical deaths due to acute crisis. Following the administration of iodine in adenomatous goiter with hyperthyroidism, the mortality is slightly lower but the decrease is not so marked. They advise, as a matter of expediency and safety, the administration of iodine in such cases, to avoid the possibility of a fatal accident consequent to an erroneous preoperative clinical diagnosis, which consists in mistaking exophthalmic goiter, with an incidental adenoma of the thyroid gland, for adenomatous goiter with hyperthyroidism.

The care of diabetic patients with hyperthyroidism has been studied by Fitz, Wilder, Joslin and Lahey, who have demonstrated that the need for insulin is greatly increased when the patient is on the verge of a crisis. Wilder has shown that as the exophthalmic patient improves as a result of iodine, the carbohydrate tolerance increases with resultant decrease in the requirement of insulin.

Since the institution of iodine therapy, not only has the patient been helped medically, but the need for preliminary and other surgical procedures has been greatly diminished at a very great economic saving. By the general improvement of the patient's preoperative condition and elimination of the long feared and dangerous complications, it may be said that treatment by iodine has placed surgery of exophthalmic goiter on a sound basis, similar to that of other branches of general surgery.

In conclusion, when we consider the advances made during the past half century in our knowledge of the chemistry, physiology and pathology and its practical application to treatment, we may feel proud, but there are still problems to be solved, new fields to explore. We realize that we have no definite knowledge of the cause of exophthalmic goiter, how it is stimulated to activity, or of the relationship and inter-relationship between the thyroid and the other endocrine glands.

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INFLUENZA AND PNEUMONIA

Influenza is caused by a filterable virus. It produced widespread havoc throughout the world several times in the middle ages, also definitely in 1847, 1889-90 and in 1918. In times when no epidemic is in progress many cases of grippe occur which are indistinguishable from those seen in an epidemic and are apparently examples of the same disease. The disease is spread from person to person by contact as in the case of the common cold and the same method may be used to prevent such spread. As the patient is usually much sicker than the person with a "cold" it is ordinarily easier to keep him from spreading his disease by keeping him isolated, but in the early stages before the condition is recognized he is very likely to infect others.

The treatment of an attack of influenza is much like that of a "cold." Fluids should be taken in large quantities, as in any infectious disease, and of the fluids that are appropriate water and fruit juices stand first. Medication should be for the relief of symptoms. As far as checking the spread of influenza is concerned the patent helplessness that was evident in 1918 may, we hope, be remedied before the next pandemic appears, for at the present time experimental studies are being carried out in various parts of the world that give rise to the hope that in time some type of truly preventive inoculation may be devised which can be used on a large scale to raise the general resistance of the population as is done in the case of vaccination against small pox.

The condition which is most dreaded as a complication of both colds and influenza is pneumonia. Lobar pneumonia is a medical emergency. The researches of the past quarter of a century have resulted in the preparation of sera which if used promptly and in sufficient quantity may save the life of a pneumonic patient who otherwise would die. As most lobar pneumonia is caused by the pneumococcus and as many different types of this organism exist it is necessary as quickly as possible by tests of the expectorations and of the blood to determine the type of pneumococcus found and its presence in or absence from the blood stream. A large proportion of the severe pneumonia which occurs is caused by pneumococci of types against which efficient sera are available, and the sooner such sera are applied in adequate quantities the greater the likelihood of recovery. In many instances the early use of the proper serum gives results that are truly spectacular.

Besides serum treatment there are many other measures which help the patient in his struggle against his infection. First and most important is good, skillful, trained nursing. The value of this factor may seem obvious but it is unquestionably a fact that many preventable deaths from pneumonia occur as a result of the well meant but bungling attentions of amateur nurses. Second is the use of oxygen. This, in many grave cases of pneumonia is life saving.

While for years pneumonia will probably continue to be one of the commonest causes of death the measures just described, especially the prompt and adequate use of serum, will every year reduce its ravages. By a proper awareness on the part of the public as to the nature of this disease, its relation to colds and influenza, and the main methods that are available for the prevention and cure of these conditions, not only can many more afflicted individuals be saved year after year, but also there will be a greater public support for study and research in this field and eventually one of the greatest health hazards of modern life may be in great part overcome.

PROVIDENCE MEDICAL ASSOCIATION

Minutes of the October Meeting

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Alex M. Burgess, on Monday, October 10, 1938, at 8:40 P. M.

The minutes of the last meeting were read and approved.

Mr. James P. Adams, vice president of Brown University, spoke briefly regarding the urgent needs of the Providence Community Fund in its annual drive.

The Secretary reported for the Standing Committee that the applications of the following for membership had been approved by the Committee:

Carmine T. Angelone
Clarence E. Bird
Samuel D. Clark
Donald L. DeNyse
William H. Foley
Richard J. Kraemer
Thomas L. O'Connell
Paul J. Rozzero
Bernard I. Sherman
William P. Shields
Edmund J. Sydlowski
Charles Zurawski

On motion of Dr. Mowry these men were elected to membership.

The Secretary reported for the Standing Committee that it had given its approval to the following proposals or projects:

1. The appointment of a Publicity Committee to handle press and radio news of the Association.

2. The appointment of a Publication Committee to consider the feasibility and advisability of a monthly bulletin to be published by the Association, and to deal principally with matters of economic and social significance.

3. The appointment of a Legislative Committee to work in close connection with the Legislative Committee of the Rhode Island Medical Society.

4. The sending out of a personal information questionnaire by the Executive Secretary for the purpose of compiling a complete office record for the Association.

The recommendations were approved by the members present.

Dr. Henry S. Joyce reported for the Committee on Group Hospitalization. This report was accepted and placed on file.

Dr. Eske Windsberg reported for the Committee in charge of the A. M. A. Survey of the Need and Supply of Medical Care. The report was accepted.

In the abscence of Dr. Edward McLoughlin the Secretary read a report of the Committee on Public Relations in which the committee requested an interpretation by the Standing Committee of the scope of its duties and suggested the appointment of a Publicity Committee to handle press and radio news matters of the Association. The report was accepted and placed on file.

Dr. James Fagan reported for the Committee on the Medical Care of Those on Temporary Relief, and stated that the problem before the committee had been settled by the city authorities on their own initiative and in accordance with their own opinions as to the best solution. It was voted to accept the report and to discharge the committee.

The President announced the appointment of the following committees:

Obituaries:

Of Dr. B. Frank Gray
Dr. G. S. Mathews and Dr. W. S. Streker
Of Dr. W. H. Higgins
Dr. J. A. Gilbert and Dr. Carl R. Gross
Of Dr. J. F. McCusker
Dr. J. E. Donley and Dr. J. P. Cooney
Of Dr. C. W. Skelton
Dr. Adolph R. V. Fenwick and Dr. George E. Teehan (By invitation)
Of Dr. D. S. Latham
Dr. A. T. Jones and Dr. P. Williams
Of Dr. Van Lee Fitzgerald
Dr. H. Partridge and Dr. G. Shattuck

Committee on Legislation:

Dr. J. Merrill Gibson, Chairman; Dr. William A. Mahoney; Dr. Milton Goldberger; Dr. Ralph DiLeone, and Dr. Roland Hammond.

Committee on Publicity:

Dr. Russell S. Bray, Chairman; Dr. Guy W. Wells, and Dr. Herman A. Lawson.

Committee on Publications:

Dr. Eric Stone, Chairman; Dr. John Langdon, and Dr. Daniel V. Troppoli.

The President informed the members present that the executive secretary, Mr. Farrell, has visited medical society offices in Syracuse, Rochester, Buffalo, Toledo, Cleveland, and Detroit during the summer and had compiled a detailed report of his study of their activities which would be presented at a subsequent meeting of the Association. In the meantime the report would be available at the exec-

utive office in the Medical Library to anyone interested.

The first scientific paper of the evening was presented by Dr. Charles A. McDonald, and was entitled "Brain Tumor Without Increased Intracranial Pressure." The second paper was presented by Dr. Robert J. Williams, and was entitled "Increased Intracranial Pressure Without Tumor."

Following the presentation of these papers, Milton Korb, a research associate, gave a very complete and interesting presentation of his subject entitled "Formation of the Circle of Willis and Its Aneurysms."

The papers were discussed by Dr. John E. Donley.

The meeting was adjourned at 10:45 P. M.

Attendance 107.

Collation was served.

Respectfully submitted

HERMAN A. LAWSON, M.D., *Secretary*

Minutes of the November Meeting

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Alex M. Burgess, on Monday, November 7, 1938, at 8:45 P. M.

The minutes of the last meeting were read and approved.

Mr. Joseph Breen, secretary to the State Director of Labor, spoke briefly regarding the medical aspects of labor legislation.

The Secretary reported for the Standing Committee that the applications of the following for membership had been approved by the Committee:

Valeria R. Juracsek

Jack Savran

On the motion of Dr. Mowry these applicants were elected to membership.

The Secretary reported for the Standing Committee that it had given its approval to the following proposals:

1. That the Association recommend to the Community Fund, Inc., that the last retiring President of the Providence Medical Association be appointed each year as the head of the Health Division of the Community Fund for the succeeding year for its annual drive.

2. That a large and representative committee be appointed by the President to aid in the Community Fund Drive.

3. That the Publicity Committee be authorized to have the Providence Journal Company appoint one of its authorized representatives to aid the Publicity Committee in matters pertaining to news information of medical nature emanating from this Association.

4. That the posting of notice of all regular meetings of the Association be permitted in the daily press.

5. That a membership committee be appointed by the President, to consist of five members, for the purpose of studying the rules and regulations concerning membership in the Association for the purpose of possible revisions.

6. That the executive secretary be authorized to send notices of the Association's radio programs to schools and clubs, and the expense incident thereto be borne by the Association.

7. That the President, at his discretion, may omit the reading of obituaries and also the personal data and qualifications of new applicants, at the regular meetings of the Association, but that at each meeting the members present shall be notified that copies of obituaries, and also the complete applications of new members, are available to any member interested through the Secretary.

On the motion of Dr. Langdon these recommendations were approved.

In the absence of Dr. Bray the Secretary read a report of the Publicity Committee which was approved and placed on file.

The President announced that he would omit the reading of obituaries unless any member wished such readings, and it was further announced that copies of the obituaries of Dr. D. Frank Gray, Dr. William H. Higgins, and Dr. Creighton W. Skelton, were on file with the Secretary.

Mr. Farrell, the executive secretary, spoke briefly regarding his visit to medical society offices in New York state, Ohio, and Michigan, and outlined some of the work being done by those groups.

The President announced the appointment of a Membership Committee as follows: Dr. Frank B. Littlefield, Chairman; Dr. George B. Waterman, Dr. Banice Feinberg, Dr. William P. Davis, and Dr. Herman A. Lawson.

There being no further business, the President turned the program over to Dr. Herman C. Pitts, who acted as Chairman of a one hour panel discussion on the topic "Co-operation in the Cancer Problem."

Dr. B. Earle Clark opened the discussion with a paper on the role of the pathologist, and then Dr. Peter P. Chase discussed the role of the surgeon in the problem. The role of the gynecologist was presented by Dr. George W. Waterman, and that of the radiologist by Dr. Isaac Gerber.

The papers were discussed from the floor by Dr. Charles N. Raymond, D. Lucius C. Kingman, Dr. John Langdon, D. Anthony Corvese, and Dr. John Dziob.

The meeting was adjourned at 10:45 P. M. Attendance was 130. Collation was served.

Respectfully submitted,
HERMAN A. LAWSON, M.D., *Secretary*

MEMORIAL HOSPITAL

INTERNE ALUMNI CLINIC DAY

Wednesday, November 2, 1938, the Memorial Hospital held its Annual Interne Alumni Clinic Day with an attendance of two hundred physicians in the morning and more than three hundred at the afternoon session. At the morning session a surgical operative clinic, under the direction of Dr. Charles H. Holt, Chief of the Surgical Division, was given by Drs. William P. Davis, G. Raymond Fox and Henry J. Hanley. Under the direction of Dr. Francis B. Sargent, Chief of the Ear, Nose and Throat Division, a radical mastoid operation was done by Dr. Nathan A. Bolotow. A urological operative clinic, under the direction of Dr. J. Edwards Kerney, Chief of the division, was given by Drs. Stanley Sprague, Mihran A. Chapian and Charles L. Farrell.

The following medical clinics were given under the direction of Dr. John F. Kenney, Chief of the Medical Division:—"Presentation of Cases of Gastric Hemorrhage," by Dr. Jacob Greenstein; "Discussion of Medical Phases of Gastric Hemorrhage," by Dr. Kenney; "Discussion of Surgical Phases of Gastric Hemorrhage," by Dr. Henry B. Moor.

At the ear, nose and throat clinic, Dr. Francis B. Sargent, Chief of the division, presented a "Discussion of Acute and Chronic Middle Ear Infections." The obstetrical clinic, under the direction of Dr. John G. Walsh, Chief of the division, consisted of a "Round Table Discussion: Management of the Complications of the First Stage of Labor," by Drs. Walsh, George W. Waterman and Albert L. Potter. D. Raymond F. Hacking, Chief of the Eye Division, showed "Moving Pictures of Eye Operations." Dr. William B. Cohen showed a "New Treatment for Birth Marks, with a Case Presentation." At the neurological clinic, Dr. John E. Donley pesented "Injuries to the Head and Their Treatment."

The orthopedic and pediatric clinic, under the direction of Dr. Roland Hammond, Chief of the Orthopedic Division, consisted of a "Short Symposium on Oeteomyelitis in Children," presented by Drs. Hammond, Herbert E. Harris and Reuben C. Bates. The pediatric clinic, under the direction of Dr. Earl F. Kelly, Chief of the division, was a "Discussion of Appendicitis in Children," presented by Drs. Kelly, Arthur T. Jones, Consultant, and Eliot A. Shaw, Assistant Surgeon.

The surgical clinic, under the direction of Dr. Frederic V. Hussey, was a "Symposium on the Handling of Gall Bladder Disease at the Memorial Hospital," presented by Dr. Hussey, Chief of the Surgical Division, Dr. John F. Kenney, Chief of the Medical Division, Dr. Meyer Saklad, Chief of the Anesthesia Division, and Dr. Emanuel W. Benjamin, Roentgenologist.

From 1:30 to 2:30 P. M. a buffet luncheon was served at the hospital to all those present.

At the afternoon session, Dr. John F. Kenney presided. The program follows:

"OBSTRUCTIVE UROPATHY," Dr. Alexander Randall, Medical Professor of Urology, University of Pennsylvania.

"CORONARY INSUFFICIENCY," Dr. William D. Stroud, Professor of Cardiology, University of Pennsylvania, Graduate School of Medicine.

"ENDOCRINE THERAPY IN THE TREATMENT OF ALLERGIC DISORDERS," Dr. Harry Bond Wilmer, Assistant Professor of Clinical Immunology, University of Pennsylvania, Graduate School of Medicine.

"ACUTE HEPATIC CELLULAR DISEASE," Dr. George Morris Piersol, Vice Dean for Medicine, University of Pennsylvania, Graduate School of Medicine.

The regular staff dinner was held in the evening at the Squantum Club.

A regular clinical pathological conference was held at the hospital on November 8. A case of appendiceal abscess on stump that had been left in at previous operation was reported by Dr. William P. Davis and discussed by Drs. Greenstein and Benjamin. A case of perforated gastric ulcer was

presented by Dr. John F. Kenney. An outline of the surgical treatment to be followed was brought out by Dr. Frederic V. Hussey and Dr. Arthur T. Jones. A case of bronchiogenic carcinoma with specimen and micro-photographs was presented by the medical service and discussed by Drs. Eliot A. Shaw, William P. Davis, Frederic V. Hussey, Jacob Greenstein, Emanuel W. Benjamin, T. Krolicki, Harry M. Kechijian and John F. Kenney.

A valuable addition to the vascular service is the vasculator which has recently been presented to the hospital.

The following doctors have completed their internships at the hospital this year:

Dr. John F. Chace, in June, at present interning at the State Sanitarium at Wallum Lake.

Dr. Durtad R. Baronian, in June, at present interning at the Boston City Hospital.

Dr. James P. Healey, in June, now practicing in Central Falls.

Dr. Edward Foster, in August, now practicing in Pawtucket.

Dr. Albert D. Spicer, in August, now attending Harvard Dental School.

Dr. Joseph B. Crowley completed a year's internship in August since which time he has married and at present is living in Franklin, Massachusetts.

Dr. Lawrence A. Senseman, who interned at this hospital in 1937, attended the Harding Sanatorium at Worthington, Ohio, and is now practicing at 160 Chapel Street, Saylesville.

RECENT BIRTHS

A son to Dr. and Mrs. Edwin B. Gammell.

A son to Dr. and Mrs. John H. Gordon.

A son to Dr. and Mrs. Joseph H. Doll.

RECENT MARRIAGES

Dr. Frederic V. Hussey and Mrs. Genevieve M. Roblee.

Dr. J. B. Curtis and Miss Elizabeth Tompkins, R.N.

Dr. Earl J. Mara and Miss Ruth Small, R.N.

Dr. Thomas J. Dolan and Miss Bertha Anderson, R.N.

Dr. Henry J. Hanley and Miss Margaret Egan.

Rhode Island Hospital

October 1st, Dr. William W. Teahan began a six months' internship at the Lying-In Hospital.

Dr. Albert A. Stitt, of Boston, Mass., became resident night superintendent on October 1st. Dr. Stitt is a graduate of Tufts College and the Medical School of Lausanne University. He interned at the Long Island Hospital, Boston, for one year and was Resident in the same institution for one year.

October 15th, Dr. Edward Lincoln Smith, II, of Montpelier, Vermont, began a two years' internship. Dr. Smith is a graduate of Yale University and Harvard Medical School. Previous to coming to the R. I. Hospital, Dr. Smith interned for one month at Providence Lying-In Hospital.

October 1st, Dr. D. William J. Bell began a six months' internship at the Charles V. Chapin Hospital. Dr. Bell, whose home is in Providence, interned at the R. I. H. for two years before going to the Chapin. He is a graduate of Brown University and McGill Medical School.

Dr. Eugene Field of Providence, who was summer intern in 1934, substituted for Dr. Boyd in the X-ray Department during the latter's absence for six weeks. Dr. Field graduated from Brown University in 1931 and Columbia Medical School in 1935. He interned at the New Haven Hospital in surgery in 1935 to 1936, later was X-ray resident at the Beth Israel Hospital in Boston from June 1936 to September 1937. He had a fellowship in gastroenterology at the Johns Hopkins Hospital and Medical School for the academic year 1937-1938 and was awarded the full Signa XI at Johns Hopkins University in research in 1938. Dr. Field is now for an indefinite period at Mt. Sinai Hospital, New York, continuing work in gastroenterology. He anticipates opening an office in Providence.

On November 1st, Dr. Bryon L. Sweet completed his two years internship. Accompanied by his wife, he left for his home in Tarrytown, N. Y., where he intends to enter practice. Dr. Sweet is a graduate of Wesleyan College and Yale University Medical School.

On November 14th, Dr. George E. Kirk of 56 High Service Avenue, North Providence, began a two years internship. Dr. Kirk is a graduate of Brown University and McGill Medical School.

RECENT BOOKS

PRACTICE OF MEDICINE. By Jonathan C. Meakins, M.D., LL.D., Professor of Medicine and Director of the Department of Medicine, McGill University. Second Edition, pp. 1413, with 521 illustrations, 43 in color. Cloth, $12.50, The C. V. Mosby Company, St. Louis, 1938.

In the preface of this large volume the author states that he has written for the student and practitioner and has endeavored to stress symptomatology. This purpose has been faithfully followed and the fundamental features of an exhaustive list of diseases is lucidly presented.

A brief idea of the scope of the book can be obtained from a list of the chapter headings: "An Introduction to the Practice of Medicine," "Diseases of the Nasopharynx and Mouth," "Specific Infections of the Nasopharynx and Mouth," "Diseases of the Larynx and Bronchial System," "Diseases of the Lungs," "Diseases of the Circulatory System," "Diseases of the Serous Membranes, Mediastinum and Diaphragm," "Diseases of the Hematopoietic System," "Diseases of the Gastrointestinal Tract," "Diseases of the Liver and Bile Passages," "Diseases of Nutrition," "Diseases of Metabolism," "Diseases of the Ductless Glands," "Diseases of the Nervous System," "Diseases of the Locomotor System," "Diseases of the Urinary System," "Infectious Diseases Conveyed by Parenteral Inoculation," "Diseases due to Allergy," "Diseases due to Abnormal Environments," "Diseases due to Chemicals and Drugs." At the end of each chapter is a short list of selected references of the subjects discussed.

In the introductory chapter the author presents an excellent general discussion of diagnosis, prognosis and treatment. He urges critical objective observation in all our work and points out that "We too often flatter ourselves that our remedies have wrought miraculous cures which, however, we cannot repeat because we have not given due credit to the recuperative capacity of biological processes which often struggle in vain against our interference."

The outstanding feature of the book is the large number of excellent illustrations which are notable because of the clarity with which they emphasize the point under discussion. Included also are many striking color plates.

The chief criticism that might be offered is the undue brevity and concomitant omission of important detail evident in some of the discussions of treatment. Thus, in a fairly long discussion of pneumonia, less than one page is devoted to the theory and practice of serum therapy. In the chapter on "Diseases of the Hematopoietic System" are several excellent color plates of the sternal marrow stained with Giemsa's stain. Though these are undoubtedly of considerable value, it might have been more helpful to use color plates of blood smears stained by Wright's method.

The printing is well done, and the type is large and easily read. The book can be strongly recommended as fulfilling the purposes outlined by the author of writing a text-book for student and practitioner.

FRANK B. CUTTS, M.D.

ANUS, RECTUM, SIGMOID, COLON, DIAGNOSIS AND TREATMENT. By Harry Ellicott Bacon, B.S., M.D., F.A.C.S., F.A.P.S. pp. 855 with 487 illustrations, Cloth, $8.50, J. B. Lippincott Company, Philadelphia, 1938.

The author has presented an orderly text, most comprehensive in scope, of his subject. By way of preface anatomy, examination, and laboratory tests are reviewed, and anesthesia discussed. The many pathological processes afflicting the anus and rectum are considered with regard to diagnosis, and both medical and surgical management. Perhaps the outstanding feature of this work is the presentation of the surgical treatment of carcinoma of the rectum and sigmoid colon. The many operative techniques are presented in sufficient detail with adequate illustration. The various procedures are well evaluated by exhaustive statistical studies. In the manner in which this material is offered the book far surpasses many surgical textbooks.

This volume is recommended as an authoritative reference source to any physician interested in proctologic and colon surgery. For the specialist in this field the extensive bibliography alone should make it a necessary addition to his library.

LAWRENCE T. MINISH, JR., M.D.

FEMININE HYGIENE IN MARRIAGE. By A. F. Niemoeller, A.B., M.A., B.S. pp. 155 with 6 illustrations. Cloth, $2.00, Harvest House, New York, 1938.

MICROBIOLOGY AND PUBLIC HEALTH. By William Barnard Sharp, S.M., M.D., Ph.D. pp. 492 with illustrations, Cloth, $4.50, The C. V. Mosby Company, St. Louis, 1938.

YOU CAN SLEEP WELL. By Edmund Jacobson, M.D. pp. 269, Cloth, $2.00, Whittlesey House, McGraw-Hill Book Company, Inc., New York, 1938.

OUTLINE OF ROENTGEN DIAGNOSIS. By Leo G. Rigler, B.S., M.B., M.D. An Orientation in the Basic Principles of Diagnosis by the Roentgen Method. pp. 212, Student Edition, $3.00. Complete Edition with 254 illustrations and atlas, $6.50, J. B. Lippincott Company, Washington Square, Philadelphia, 1938.

SICKNESS INSURANCE IN EUROPE. By J. G. Crownhart, Secretary, State Medical Society of Wisconsin. pp. 134, Cloth, $1.00, J. G. Crownhart, Madison, Wisconsin, 1938.

SYNOPSIS OF CLINICAL LABORATORY METHODS. By W. E. Bray, B.A., M.D. Second Edition, pp. 408 with 51 text illustrations and 17 color plates, Cloth, $4.50, The C. V. Mosby Company, St. Louis, 1938.

THE 1938 YEAR BOOK OF GENERAL MEDICINE. Edited by George F. Dick, M.D., J. Burns Amberson, Jr., M.D., George R. Minot, M.D., S.D., F.R.C.P., William B. Castle, M.D., A.M., William D. Stroud, M.D., and George B. Eusterman, M.D. pp 840. with illustrations and a color plate, Cloth, $3.00, postpaid, The Year Book Publishers, Inc., Chicago, 1938.

HOW TO CONQUER CONSTIPATION. By J. F. Montague, M.D., Editor-in-chief of Health Digest. pp. 244, Cloth, $1.50, J. B. Lippincott Company, Philadelphia, 1938.

DOCTOR BRADLEY REMEMBERS. A Novel by Francis Brett Young, author of "They Seek a Country." pp. 522, Cloth, $2.75, Reynal & Hitchcock, New York, 1938.